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Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

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REHABILITATION

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N. C. ALCOHOLIC REHABILITATION CENTER

BUTNER, N. C.

About the Center . . .

The A.R.C., as it has come to be known, is a 50 bed in-residence treatment facility for problem drinkers. Located at Butner, N. C., a small community approximately 12 miles north of Durham, N. C. off Highway 15, it is operated under the authority of the N. C. Department of Mental Health. The Center provides residence, treatment and workshop facilities for 38 male and 12 female patients.

A.R.C. Treatment Methods . . .

Treatment is by psychotherapy and consists of group discussions led by the professional staff, educational films, individual consultations with staff members, vocational guidance, recreation, rest, proper food and prescribed medications.

Length of Stay . . .

The basic treatment program is based on a 28-day schedule. The patient may remain for a longer period if, in the opinion of the staff, it will be of further therapeutic benefit to him. No applications for less than 28 days are accepted.

Admission Requirements . . .

1. Persons desiring admission must come voluntarily. No one can be admitted by court order. The individual who is sincere in wanting help and who comes voluntarily stands a much better chance of successful rehabilitation.

2. An appointment for admission is obtained by written or telephone application to the Admitting Officer, 406 Central Ave., Butner, N. C. (telephone 919 985-6770). All appointments are confirmed by mail. Preferably they should be made through a physician or other professional person in the prospective patient's community.

3. Since the Center is not designed, nor equipped, as a sobering up facility, the prospective patient must not have taken any alcoholic beverages for at least 72 hours prior to admission.

4. A report of a recent physicial examination by a duly licensed physician must be presented prior to or at the time of admission. The prospective patient's physical condition must be reasonably good enough to enable him to participate fully in all phases of the treatment program. There are no medical beds for the treatment of serious physical or mental disorders.

5. A fee of $75 in cash or certified check only must be paid at the time of admission. No personal checks can be accepted! Cases of true indigency must present written evidence in the form of a letter from their county welfare department at the time of admission or before.

6. A social history, compiled by a trained social worker in the local welfare or family service agency or other professional organization is required. Arrangements for the history should be made early enough so that it reaches the Center within a week following admission.

Admitting Days . . .

In order to facilitate the program of treatment by the small group method, prospective patients are admitted on Wednesdays, Thursdays and Fridays from 8 to 12 a.m. and 1 to 5 p.m. In this manner several days of adjustment to the life of the Center are provided before the beginning of the intensive treatment program the following Monday.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA DEPARTMENT OF MENTAL HEALTH

NORBERT L. KELLY, Ph.D.
Associate Director

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THE MOST NEGLECTED PROBLEM PATIENT

IN many medical practices, at least one out of 10 patients is an alcoholic. His problem is apt to be unidentified—or, if it has been recognized, he may be shunned as an undesirable or put on a course of treatment that's all wrong. Yet success in treating such a patient depends in large part on techniques that are familiar to family doctors—taking a careful history, establishing rapport, seeing him daily when symptoms are acute, avoiding lectures.

Is the alcoholic as difficult to discover, slow to pay, hard to handle as many doctors think? No, say three M.D.'s who have treated alcoholics successfully. They recently met with Gene Balliett, senior editor of *Medical Economics,* a national magazine for physicians, to review their techniques. The participants in the discussion:

Alfred Auerback, M.D., a psychiatrist who practices in San Francisco. He's a director of the San Francisco Council on Alcoholism and an associate clinical professor of psychiatry at the University of California School of Medicine.

Ruth Fox, M.D., medical director of the National Council on Alcoholism, New York. She has specialized in treating alcoholic patients for the past 25 years.

Stanley E. Gitlow, M.D., a New York family doctor. He is an associate clinical professor of medicine at New York Medical College.

What follows is a condensation of their discussion.

BALLIETT: A number of doctors have told me they want nothing to do with drunks in their practices. Have you ever heard that sort of statement from your colleagues?

DR. AUERBACK: I've heard that many times. Relatively few doctors know about alcoholism as a disease. Many doctors look upon the alcoholic as just an undesirable person, and they want no truck with him. And yet more than 10 per cent of the patients seen in many medical men's practices are undiagnosed alcohol addicts. The alcoholic, then, may well be the most neglected patient in America today.

DR. FOX: The neglect has been documented many times. For instance, in one study 100 adult patients were chosen at random in a general community hospital, then interviewed and examined; 30 of them were alcoholic, and the diagnosis had been missed in each case. The sad part of that study, and there have been others like it, is that alcoholism is an illness much like cancer, in that the sooner a doctor gets to it, the better his chances of curing it.

DR. GITLOW: And despite some

Since more than 10 per cent of the patients seen in the practices of many physicians are undiagnosed alcohol addicts, the alcoholic may well be the most neglected patient in America.

widely held misconceptions, the fact is that most alcoholics can be dealt with successfully. Once a solid doctor-patient relationship is established, a doctor can start re-educating his alcoholic patient.

DR. FOX: Many people are alcoholic without knowing it, or at least admitting it, so educating them can be a challenge. They may say, "Well, I don't drink any more than my friends do." Words like those may be a sign that they honestly do not recognize that they're addicted to alcohol.

DR. AUERBACK: A person with a drinking problem doesn't usually tell a doctor "I drink too much." In fact, he may not realize that he does. Instead, he comes to the doctor because he can't sleep, his stomach is upset, he just doesn't feel up to par, or for whatever secondary reason is most noticeable at the moment.

DR. FOX: Whenever a doctor hears such complaints, he should find out what the day's drinking routine is. Does a man have a hangover when he wakes up? Does he take an early morning drink? Does he drink again at lunch and after work? Just as you ask "How much do you smoke?" you have to ask "How much do you drink?"

You must go into patients' drinking habits as a matter of routine. Otherwise, you risk letting an alcoholic reach a point where his drinking can be very, very serious.

DR. GITLOW: Right after a bender is probably the time to start educating a patient who has a drinking problem. He then not only feels guilty but suffers physically, and a physician has an opportunity to demonstrate his feeling towards him. He can relieve his suffering and he can show sympathy and understanding during the withdrawal period. The patient's guard isn't as high then as it is when he's feeling good and believes he can handle his liquor. So the doctor is in a good position to talk with him meaningfully—that is, as a physician to an alcoholic—for the first time.

BALLIETT: What should a doctor try to accomplish in that first session?

DR. FOX: The first thing is to make the patient feel that he's a worthwhile individual. To do that, the physician must get to know the patient as a person. That first interview can be spent just talking about the patient's family, his job and his social life. The goal, in other words, is to see him as a total human being. This is very important.

DR. GITLOW: The doctor has to do lots of listening. I don't know how else he can establish any rapport with the patient. And rapport is the foundation of successful treatment.

The doctor needs to know, very quickly, where the patient has had trouble. Has he had trouble holding jobs? In interpersonal relationships? At home? How satisfied with him are the people who are close to him? Are his wife and children happy with him? Knowing the answers will help the physician make a more accurate estimate of the patient's motivation —and hence of his prognosis.

DR. FOX: The doctor should also find out what the patient thinks of

(Continued on page 6)

A feature designed to help you keep posted on developments in the field of alcoholism.

EDITOR'S NOTE: Inventory, after 15 years' publication as a **bi-monthly** journal, will be published **quarterly** in the future. Otherwise, it is anticipated that present policy, format and quality of content will be preserved.

WINSTON-SALEM, N. C.: Marshall Abee, president of the Alcoholism Programs of North Carolina, has resigned his position as executive director of the Alcoholism Program of Forsyth County to become executive director of Community Health Services, Inc. in Greensboro. He will begin his new duties August 1. Abee, an outstanding leader and personality of the alcoholism control move-in North Carolina, was serving his second two-year term as president of the APNC at the time of his resignation. As many "friends of alcoholism" who have worked with Abee know, behind his outwardly calm and easy-going manner is a man who exercises a keen mind and determined soul. Abee "fought the good fight" ever placing principles before personalities. His leadership in alcoholism will be missed but, undoubtedly, his friendship and influence will not be lost to the cause. He's that kind of man.

17TH NAAAP ANNUAL MEETING: "Coordinated Alcoholism Programming and Planning" will be the theme of the 17th annual meeting of the North America Association of Alcoholism Programs to be held October 9-13, 1966 at the Hilton Hotel, Albuquerque, New Mexico. Hosted by the New Mexico Commission on Alcoholism, co-hosts to the meeting will be the Texas Commission on Alcoholism and the Utah Board on Alcoholism.

REGIONAL PLANNING MEETINGS ON ALCOHOLISM: The N. C. Department of Mental Health and the Alcoholism Programs of North Carolina have been the joint sponsors recently of four regional planning meetings on alcoholism. The purpose of the meetings was to plan a workshop or conference on alcoholism for each of the regions to be conducted this fall which would include, in addition to the sponsors, representatives of other agencies that work with alcoholics. The regions are those defined by the department of mental health which are set up on the basis of counties served by the state mental hospitals. The state hospitals and regions are linked as follows: Eastern Region, Cherry Hospital, Goldsboro; Western Region, Broughton Hospital, Morganton; North Central Region, John Umstead Hospital, Butner; and South Central Region, Dorothea Dix Hospital, Raleigh. For the number of counties in each region, see the picture story on page 16 and 17.

The regional planning meetings were chaired by staff members of the department of mental health and met as follows: Eastern on May 19 at

Cherry Hospital in Goldsboro, chaired by Dr. Norbert L. Kelly; Western on May 24 at Broughton Hospital, Morganton, chaired by Dr. William Fowlkes; North Central on May 25 at the YWCA, Durham, chaired by Dr. Charles Vernon; and South Central on June 1 at the Emmanuel Episcopal Church, Southern Pines, chaired by Dr. N. E. Stratas.

The meetings were attended by approximately 90 people, with 30 in attendance at the Eastern Regional Planning Meeting and 20 each at the Western, North Central and South Central meetings. The following agencies and disciplines were represented at all four meetings: department of mental health, local alcoholism programs, state mental hospitals, local health and welfare departments and private physicians. Represented at one or more, but not all four, were: ABC boards, mental health associations, mental health centers, general hospitals, state prison department, the Alcoholic Rehabilitation Center at Butner, N. C. Board of Mental Health, Division of Vocational Rehabilitation of the N. C. Department of Public Instruction, private alcoholism treatment facilities, family service societies, ministers, clerks of court, judges, law enforcement and parole officers and legislators.

All regions had to schedule one or more committee meetings to complete plans for the fall workshops or conferences on alcoholism.

SUMMER SCHOOLS: Summer Studies on Facts About Alcohol for teachers and prospective teachers have been completed at East Carolina (June 7-17) and North Carolina (June 27-July 8) colleges. A third course is in progress at Winston-Salem College (July 5-27). The 4th annual Summer School of Alcohol Studies (June 19-25) at the University of North Carolina had 93 students including local council, public health, and hospital personnel, local law enforcement officers, ministers, social workers, and prison, probation and parole officers. See UNC picture story below:

himself. There is usually a very low self-image. That fact may not come out right away, but it is very much worth bringing into the open eventually.

BALLIETT: What clues in a patient's story might suggest that he's a problem drinker?

DR. FOX: Monday-morning job absenteeism, payday drinking, the deterioration of his relationships with his co-workers or with his family.

DR. AUERBACK: Don't overlook recurrent accidents. Also, of course, you need to look for such clinical symptoms as gastrointestinal or pancreatic disturbances and recurrent tuberculosis.

DR. GITLOW: And any repetitious, persistent functional disturbances—headache, fatigue, insomnia.

DR. AUERBACK: A family doctor is usually the first physician consulted by an individual with a drinking problem, whether or not that person admits that he has the problem. So a family doctor has a better opportunity of identifying alcoholic patients than does any other doctor. Also, since he probably knows the patient and his family medically, perhaps even socially, he's in a good position to get the really complete history that's often required in diagnosing alcoholism.

BALLIETT: In early sessions with an identified alcoholic, what are some ways of establishing rapport with him?

DR. GITLOW: Show compassion. Sympathize with his difficulties, whatever they may be. Never appear rushed or concerned with your own activities, the last patient or the next one. Give him adequate time and pay attention to him. Don't judge him.

DR. AUERBACK: And avoid psychiatric terminology. The moment you start using psychiatric labels, you're dead. The patient won't come back.

BALLIETT: Suppose a doctor finds out during a routine appointment that the patient is an alcoholic but doesn't know it. He can't spend much time with him then and there because other people are waiting. What should we do?

DR. GITLOW: I would have him come back—on some pretense, if necessary—so that we can talk.

DR. FOX: You can actually accomplish quite a lot with an alcoholic in just 10 or 15 minutes. You can use those moments to build this initial rapport. If you don't, chances are he won't come back at all.

A Few Don'ts

DR. GITLOW: He's got to keep coming back, because it takes lots of time to teach an alcoholic that there is nothing magic about a bottle, and there's no magic pill to cure this disease. When you've done so, you'll have taught him a great deal. For years he has been trying to find such magic. His cure depends on learning, with your guidance, that the magic doesn't exist.

So if you suddenly look at him during the initial interview and say "Hey! you're an alocholic," hitting him right in the face, you're finished. It's much better to take the history in such a way as to lead the patient to draw his own conclusion that he is having difficulty with alcohol.

DR. AUERBACK: The key to handling the initial interview is to avoid moralizing, to convey your awareness that he is sick, without necessarily mentioning alcohol, and to convey your willingness to help. These people not only have a low self-image, but a strong conviction that they can't be helped. Thus you must also convey, often indirectly, the conviction that good will come

of your relationship.

Doctors often make the mistake of telling such patients right off the bat, "You've got to stop drinking." Now, this is easier said than done. An alcoholic can't stop drinking unless you provide him with something to take the place of alcohol, a crutch. A time to tell him he must stop will come, but not right away.

BALLIETT: What makes for a good crutch?

DR. GITLOW: Alcoholics Anonymous is a very good crutch, and so are a good spouse, a healthy liver, and happy, healthy children. However, one of the best crutches is the physician himself. Sedatives and tranquilizers may play an important role in the proper management of an alcoholic who is in an acute withdrawal state. But over the long haul it's the doctor—his comfortable relationship with the patient—that counts most. If a doctor is unwilling or unable to devote the time necessary for being someone a patient can lean on, then he should refer him to someone who is willing and able.

This need for scheduling frequent office visits was brought home strongly to me not long ago. A young woman came in, and I found that she had gone years without any significant period of sobriety. During her third visit, I told her that I could not work with her while she was drinking. She stopped drinking. I realized, though, that her situation was so tenuous that I would have to replace the alcohol with some readily available support. So I scheduled her for an appointment every single day for weeks. Seeing me that often was the crutch she needed. Gradually, then, I cut back her appointments to three a week, then to two, and then to one. Now there are long periods between visits. All this time, she has remained bone-dry sober.

DR. AUERBACK: No hospitalization?

DR. GITLOW: No. I just sat and talked with her. That was it.

BALLIETT: You had to spend lots of time with her. In general, do alcoholics take more of your time than your other patients do?

DR. GITLOW: Yes. I never schedule alcoholic patients for less than 40 minutes, and never for more than 60. Less than 40 doesn't give us enough time to talk; yet little is accomplished after 60 minutes. So I schedule an alcoholic for a period equal to two or three times that of a routine office visit, depending on the individual and his stage of treatment.

BALLIETT: Do you set your fee accordingly?

DR. GITLOW: Yes. When a patient takes the time normally assigned to three routine visits, I charge three times the fee of one routine office visit.

BALLIETT: Are alcoholics prone to break appointments with their doctor?

DR. GITLOW: To some degree they are, though not so much as certain other groups are—for instance, the neurotics.

BALLIETT: Are they prone to ignore your monthly statements?

DR. GITLOW: No. They seem to be just average on that score—no better and no worse than, say, heart or ulcer patients.

BALLIETT: What is more successful—tapering off or quitting cold?

DR. GITLOW: I've been extremely unlucky with the tapering off method in the 15 years that I've been treating alcoholics. Every time I've tried to get a bona fide alcoholic to taper off uncontrolled, outside of a hospital, I have failed.

It's true that demanding complete sobriety of an alcoholic may send

him screaming to the hills. But the fact remains that no one—not Alcoholics Anonymous, not you and not me—can work with an alcoholic while he is drinking. The patient must be sober.

Alcoholics Anonymous recognized that a long time ago. If a person shows up drunk at one AA meeting after another, eventually somebody will walk over to him and say: "Buddy, save your time. Get out."

DR. FOX: This is an area where lots of psychiatrists make a mistake. They take the approach that an alcoholic is suffering from an underlying personality disorder: Take care of the personality disorder, and the alcoholism takes care of itself. That course only perpetuates the disease, since no one, not even a psychiatrist, can successfully treat an alcoholic while he is drinking.

BALLIETT: Dr. Auerback, you're a psychiatrist. Would you care to defend your colleagues?

DR. AUERBACK: No. Dr. Fox is right. No matter what a psychiatrist uncovers psychotherapeutically, his alcoholic patient is going to keep on drinking until he understands that he must stop. While many psychiatrists know that's so, many others apparently do not realize it.

DR. FOX: I have a very good case in point—a psychoanalyst who was also an alcoholic. He underwent 17 years of psychoanalysis, five times a week, with some of the best analysts here and in Europe. After he had lost his hospital privileges, his practice, his money, even his license, he finally went to a general practitioner who is very wise in the ways of alcoholics. That was more than seven years ago. Since then he has slipped but once, briefly, and he has come back professionally. He's doing very well now. Not long ago he told me:

"I had all the psychological insights. Now that I no longer drink, I can utilize them; finally they all make sense. Do you know that in those 17 years of analysis, not one psychiatrist ever said, 'You have to stop drinking'? But the G. P. did."

BALLIETT: How do you deal with those first few weeks off liquor, when the patient may find it especially hard to stay on the wagon?

DR. FOX: One good way is to explain to the patient what he can expect—that nighttime will be his most difficult period, that for a few nights he won't sleep well, and that if he can just stay away from alcohol those few days he will again experience a natural sleep. Meanwhile, you have him come in daily.

DR. GITLOW: After a patient has been off alcohol for a week or two or three, then he's pretty much finished with the acute withdrawal state.

DR. AUERBACK: Right. But he still needs a crutch.

DR. GITLOW: Now at that particular point I like to see him rely a bit less on me and a lot on AA. At the start, I prefer that he attend AA every night.

BALLIETT: What are some good ways for a doctor to learn how to deal with alcoholics?

DR. GITLOW: Experience is the best teacher, but of course it's not the only one. I think that any doctor who wants to handle alcoholism must, as Dr. Fox advised me many years ago, attend AA meetings. You have to learn about alcoholism from people who have had a great deal of experience with it. AA is one place where you can find those people.

DR. AUERBACK: Also, a doctor should learn about other resources available in his community. AA is fine, but not every patient fits into it. There are also family service agencies that he can turn to.

(Continued on page 10)

Does It Really "Take One to Know One"

BY MELVILLE THOMAS, M.S.

ACTING CHIEF CLINICAL PSYCHOLOGIST
FLORIDA ALCOHOLIC REHABILITATION PROGRAM

• *Alcoholics should be treated by other alcoholics and professional people.*

"It takes an alcoholic to help another." How often have we heard this statement?

The question of non-alcoholics treating alcoholics can become quite a complex matter. There is probably no clearcut answer, but like so many catch-questions, we would probably have to start by saying, "Well, it depends . . ."

Perhaps we ought to look at the negative side first. We know, for instance, that if non-alcoholics can be useful in the treatment of alcoholism surely not all non-alcoholics would be equally effective. As an example, we may point to a kind of individual who would most certainly not be welcome in treatment circles. He is the punitive, even sadistic, hell-fire-and-brimstone crusader who threatens the alcoholic with the damnation of the sinner. We only ask: "Does this lead to sobriety?"

On the other extreme, we find a different type of person who is equally inadequate to the task. He is the "soft touch" type who conveniently doesn't see the manipulations of the alcoholic. He is blind to the fact that alcoholics sometimes use people in many ways. To the alcoholic this kind of individual is quite naive and is just a "patsy."

How can the alcoholic have respect for either the crusader or the patsy? How can he possibly have confidence in either of them or look to them for guidance? Or, to speak more generally, how can the alcoholic seek help from anyone who is emotionally disturbed—whose behavior may be dominated by deeply rooted prejudices?

"No, thanks," replies the alcoholic, not even bothering to ask whether or not this individual even drinks. Drinker or teetotaler, alcoholic or not, the individual who is excessively punitive or who is excessively permissive probably has no part in the treatment of alcoholism.

If we agree that excessively punitive or excessively permissive people cannot help the alcoholic, we then ask the next question, "Who can?" At least we know they must have qualities other than the undesirable ones we have already mentioned.

Instead of the punitive crusader we need someone who has genuine understanding for the vise-like grip that alcohol can have on a man. It must be a deep compassion for the

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DR. FOX: In fact, more than 30 states have programs on alcoholism now, and a good many of them run clinics. Also, there are about 79 affiliates of the National Council on Alcoholism, and they're doing a very good job. They run information centers for patients and their families, and some of them have treatment facilities.

Unfortunately, many doctors mistakenly believe that alcoholics are impossible people to deal with. Yet as soon as a doctor begins to learn how to cope with them, he begins to enjoy working with them.

DR. GITLOW: Years ago I had many doubts about my ability to deal with the alcoholic. I had heard a lot of things about alcoholics that later turned out to be untrue. For instance, you will often hear that they are ungrateful patients. This just isn't so. I have as many ungrateful cardiacs as ungrateful alcoholics. The physician who learns about alcoholism can work with it as well as he can work with a cardiac or a patient with a duodenal ulcer.

BALLIETT: What mistakes do doctors commonly make when first dealing with alcoholic patients?

DR. FOX: One is using the word "alcoholic" as though it were an accusation. When you say to somebody, "You're an alcoholic," it's almost like accusing him of something. I think it's much better to say, "You probably have a problem with alcohol."

Another mistake is letting hospitals and health insurers continue to act as though alcoholism doesn't exist. To get an alcoholic admitted or to qualify him for benefits, a doctor may have to use a diagnosis like cirrhosis of the liver or gastritis or anxiety neurosis. The situation is almost medieval, and it will probably continue to be so until physicians get it changed.

DR. GITLOW: A third mistake doctors make is being aggressive in handling alcoholic patients. Such doctors get very little information out of them.

DR. AUERBACK: Failing to talk with the spouse early in treatment is another common mistake. Even the most cooperative alcoholic patient won't tell the doctor the whole truth. He will tell you as much as he has to or as much as he'll admit to himself. You have to get supplemental information from his family.

DR. GITLOW: Another mistake is failing to side with a patient against his spouse when the situation warrants it. And it frequently does, since alcoholic patients often find themselves in hostile marital situations. I've seen many an alcoholic progress to the point where his disease was arrested only to see the spouse become an active drinker in an effort to pull the patient out of therapy. In a situation like that, a doctor must face failure with his patient unless he gives him the moral support he's not getting at home, helps him see what the spouse is up to, sides with him in the battle.

BALLIETT: What else can a doctor do to help a patient out of such a situation?

DR. GITLOW: He can do his best to get the spouse either into therapy or into Al-Anon, which is an offshoot of Alcoholics Anonymous. It's for the families of alcoholics—the wives and the husbands. Al-Anon was established in 1951, and it now has more than 2,200 groups in this country.

DR. FOX: There's also an organization called Alateen, for the teen-aged children of alcoholics. It has over 350 groups mostly in this country and Canada.

The people in Al-Anon and Alateen get together to understand alcoholism and to learn what they can do to help. Attending meetings very frequently changes the alcoholic's kin from vindictive, punishing people into understanding people who can really give an alcoholic assistance. A wife, for instance, may not be responsible for her husband's being alcoholic, but she may nevertheless provoke him into benders. In Al-Anon she'll soon learn that throwing the liquor down the sink, taking away the money, withholding sex—that none of these things ever work. They simply cause more and more trouble.

DR. GITLOW: Also, Al-Anon gives a doctor a way of answering the wife who comes storming into his office, resenting both her husband and the doctor. He can sit there and turn the resentment right back by saying: "Well, what have *you* done to help? When was the last time you were at Al-Anon?" If she says she's never been there, the doctor can demand: "Why not? Your husband is ill with a disease, and there are ways in which wives have handled the situation you're in with some degree of success. The advice is available free to everybody. Why haven't you ever gone?" Such an episode may offer the first opportunity to teach the spouse how to start to cope with alcoholism in the family.

BALLIETT: How do you handle a reference to AA or Al-Anon?

DR. FOX: I give the patient their booklet, their exact address directions, and the name of the person to ask for. Once you get to know some of the people in AA, you can refer the patient to the person he can identify with most easily.

DR. GITLOW: You can do a lot of the introducing right on your office phone, while the patient is sitting opposite you.

DR. AUERBACK: You place the phone call, and you say, "I am sending over Mr. So-and-so because . . ." Then the patient won't need to explain himself to somebody else. The alcoholic, for all his show of bravado, is a scared, lonely person. He has to screw up his courage to come to you and admit: "I've got a problem. I want to do something about it." If you just say to him, "Run along to AA," that to him is another form of rejection, and he plain won't go.

DR. GITLOW: It's often a good idea to send a new patient to another patient who has his disease pretty well whipped. Both will be helped. The old patient will interpret your referral to him as a show of confidence. This will be quite an ego-strengthening thing.

DR. FOX: Alcoholism is a contagious disease; you can get it by watching the drinking habits of people who are significant in your life. But the cure is contagious, too.

BALLIETT: One final question: How do you handle a relapse?

DR. AUERBACK: You start by anticipating it. It's almost bound to come, since an alcoholic is not only a suffering human being but something of a troubled child, a mixed-up kid. When the relapse does come, you consider it an opportunity to learn still more about your patient. You can sit down together and figure out what drove him to drink. Once you know, you'll have reduced the odds of another relapse.

Also, you'll have an opportunity to establish an even greater rapport. No matter how strong it was before a relapse, your patient will now expect you to turn on him. Doing so might well sink him. So, instead, you say—sympathetically, objectively and without scolding—"That's t o u g h. We'll try again."

Needs Literature

The City of Rocky Mount Health Department needs literature on alcohol to distribute to students making written reports in our high schools. We have a copy of *Inventory* and I am wondering if you could send us about 50 free copies?

Miss Mary Anne Harrell
City Health Department
Rocky Mount, N. C.

Working With Teen-agers

We are working with teen-age groups on the problems of teen-age drinking. I feel *Inventory* would be quite helpful. Could we obtain one year's back copies?

Mrs. Nancy Hughes
Assistant Home Economics
Extension Agent
Lincolnton, N. C.

Problem of Air Force

The chaplains at Seymour Johnson are from time to time called upon to deal with members of the Air Force who have alcohol problems. I wonder if you have a list from which we could choose materials that would seem pertinent to our needs?

Captain David E. Nyberg
Chaplain, USAF
Seymour Johnson Air Force Base
North Carolina

Family Problem

Yesterday I visited Judge Donald Crist of Moab to consult with him concerning the committing of my wife (an alcoholic and pill taker for the past 8 years) to the alcoholic division of an asylum.

She has not only gotten beyond my control but is ruining my health as well as my business through my neglect because of looking after her and trying to keep her out of the jail and gutter.

Judge Crist handed me one of your *Inventory* magazines and in it I've found helpful information concerning this dreadful disease. Though my wife may have to go away, I do want to continue my learning of the subject.

Anonymous
Moab, Utah

Helpful to Clinic Patients

We would like to request some copies of your literature regarding the problem of alcohol such as that found in your information kits. We are now seeing several patients and their relatives who are confronted with the many problems which arise from alcoholism and we feel some of your literature would be helpful to them.

William W. Winborne, III, M.S.W.
Sandhills Mental Health Center, Inc.
Pinehurst, N. C.

Ministerial Request

The ministers of the Transylvania County Ministerial Association desire that the enclosed list of men be placed upon your *Inventory* mailing list. As secretary of this organization, I am making this request for the body.

Robert G. Canipe, Pastor
Glady Branch Baptist Church
Brevard, N. C.

A TRAGEDY IN THREE ACTS

The tragedy is death for the drinker and destruction of the lives of those around him—if the alcoholic is allowed to act out the drama of alcoholism.

The DRAMA of ALCOHOLISM

BY REVEREND JOSEPH L. KELLERMANN

ALCOHOLISM is a tragic drama. The alcoholic is the tragos. He becomes the scapegoat because he is an escape artist. It is also less painful for others to assist the alcoholic in each escape than it is for them to make a massive resistance to this escape mechanism. Compassion, or the capacity to suffer with a person in the process of recovery, is not easy, especially when you believe the other person has caused the whole mess. I do not employ psychodrama in counseling, and yet counseling in this field is a form of verbal description of drama—a reading or interpretation of the play.

It is a mistake to think of the alcoholic as recovering in a hospital bed. Hospitalization may save his life, but it can also be used as a method of escape. Members of my former parish died of acute and chronic alcoholism at the rate of one per cent each five years. These persons had the best doctors and the best general hospital care. Some went to the best private psychiatrists. Others entered excellent treatment centers. Several were active in Alcoholics Anonymous for periods of time. What killed these persons is that they belonged to the "best families" whose pride and shame would not let them deal with the illness realist-

This article is based on an address delivered at the 25th annual meeting of the American Society of Group Psychotherapy and Psychodrama. Published by permission of the author, Rev. Kellermann is director of the Charlotte Council on Alcoholism, Charlotte, N. C.

ically.

The alcoholic who continues to drink does so because of the many helpers who assist him in this process and thereby help perpetuate the illness. Sobriety is not to be confused with recovery, but as long as drinking continues there is no possible chance of recovery. The persons who help prevent recovery must learn their roles in this tragic drama and make drastic changes before therapy is effective. In fact, if these persons change sufficiently the alcoholic may recover without any therapy—unless there is such a profound underlying mental disorder that alcoholism is completely secondary.

Drinking is not symptomatic of the illness; it is the alcoholic's *treatment* of the illness. It is, in effect, a very unsatisfactory adjustment to the pain of living, a desperate attempt to find integration, to ward off unbearable anxiety and tension, or to release hostility. It is a means of expressing self which can not be done in sobriety, or it may be temporary suicide. Alcohol is such powerful medicine that a therapist has nothing to offer which is not weak in comparison, and this includes chemotherapy as well as psychotherapy. Treatment is ineffective if the pain of the consequences of drinking is absorbed by others or aborted from its natural interaction with the alcoholic.

If Thorton Wilder could create magic without the use of scenery and radio produced drama without viewing the actors, so can the therapist or counselor interpret the true drama of alcoholism and thereby impart insight and understanding of the problem.

Alcoholism can best be understood by viewing the alcoholic front and center on the stage of life in a three-act play named "Denial."

In Act I the alcoholic plays the

The alcoholic can be viewe

active role, or at least carries the ball. He drinks to excess and each time he drinks there are unwanted consequences. He pulls a booboo, creates a crisis, upsets the apple cart and often ends up in a jam.

In Act II three other characters (the supporting cast) appear—the enabler, the victim and the provoker. Although it is possible for one person to play all three roles, this is the exception.

As the drama is enacted, the enabler, a guilt laden savior of men, sets up a rescue operation. He represents the community by giving assurance that since one does not stay drunk forever, this recent conduct was only temporary and will not happen again. As an aside, we can see this in the life of the homeless alcoholic in the signs on store-front churches which read "Rescue Mission, Jesus Saves."

The victim is often the immediate superior or immediate inferior to the alcoholic in the economic area of life. This person covers up or accepts the drinking episodes, not because he likes the alcoholic but because of his inability to cope with the situation effectively. Thus the working relationship continues despite frequent ruptures which occur during drinking bouts.

The third, and perhaps the most fascinating, character in Act II is the provoker (usually a female) who provokes, challenges and constantly reminds the alcoholic of all his past failures. This she may do actively or passively. Regardless of what she does, she is there in a symbiotic relationship which can be nothing less than destructive unless she learns to

act like the father of the prodigal son instead of acting out this parable in complete reverse.

In Act III the stage is set for the condition of restoration but without repentence, restitution or recovery. The alcoholic's guilt is intensified, his sense of failure is enlarged, and the actions of the supporting cast in Act II have prevented the therapeutic values of reality from interacting with him.

Since the name of the play, and the nature of the illness, is *Denial,* the alcoholic in Act III must deny the reality of his rescue, compensate in some way for his failure, and continue to live with the female provoker which may in fact be nothing less than torture.

The underlying neurosis of the alcoholic has been described as one of omnipotence. This trait is revealed most actively while the alcoholic is under the influence, yet no less clearly in Act III when the alcoholic resents any inference on the part of others that he should change. The alcoholic denies or ignores Act II, but the underlying basic problem, unchanged by the enabler, victim and provoker, leads him back to the bottle.

To make this drama still more realistic and interesting, we could pursue the Jekyll-Hyde transformation which occurs when the alcoholic drinks. I find this to be the most consistent symptom of alcoholism and a problem with 99 per cent of my clients. Most wives state that they are quite fond of the man when sober but detest him when drunk. A client recently made the observation, which is far nearer the truth after this play has run for a long period of time, "It is like being married to two husbands and I have reached the point that I do not like either one of them." Therapy becomes workable when the wife and boss make a real decision to be a supporting actor for Dr. Jekyll but refuse to play supporting roles for Mr. Hyde.

It can be concluded from this drama that it is almost a futile waste of time and effort to provide therapy for an alcoholic unless the family is involved in the process. In fact it is far more important to direct attention to the supporting cast than to spend all the time and effort coaching the star of the production.

The key to recovery is the rewriting and redirection of the action in Act II of this drama. We have no right to insist that this be done, but we must provide the supporting cast the knowledge of the impact such a change may produce.

The one thing I wish to emphasize is so obvious it is generally overlooked. In the construction of a play, Act II must relate directly to Act I, and Act III must follow Act II and cannot ignore what happened in it.

If Act II of the play, "Alcoholism —A Denial of Reality," is completely rewritten and the characters begin to reverse their roles or change drastically, then Act III must be changed accordingly. Recovery occurs in this fashion, if it occurs at all. Most alcoholics die because Act II becomes as stereotyped as the second reel of a three-reel movie. The alcoholic is locked in a phase of resistance to treatment because he can

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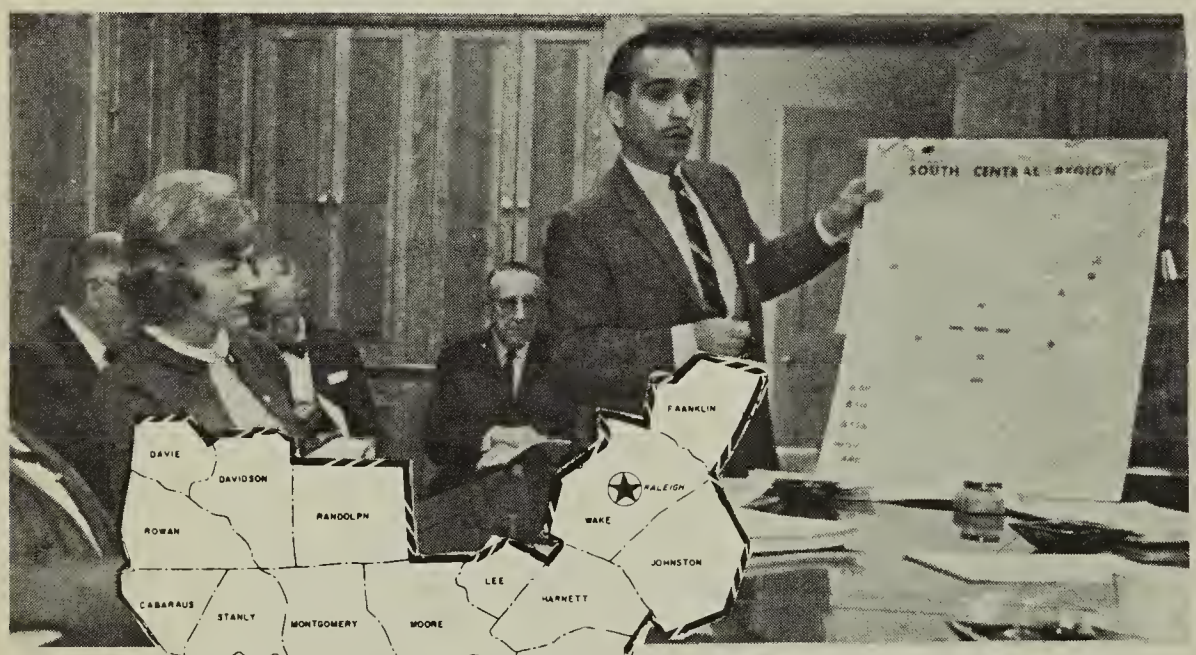
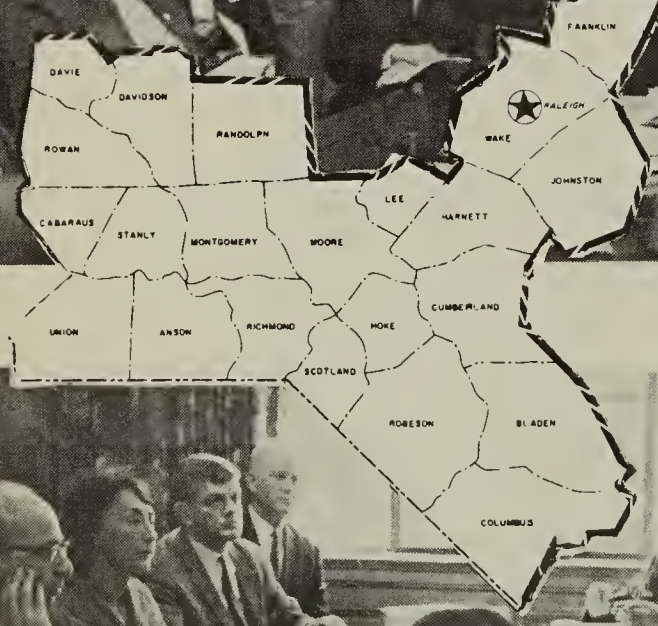
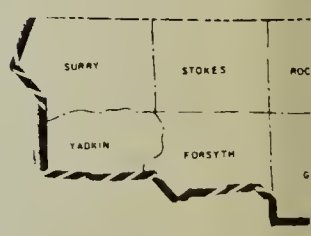
REGIONAL ALCOHOLISM

Western Region

South Central Region







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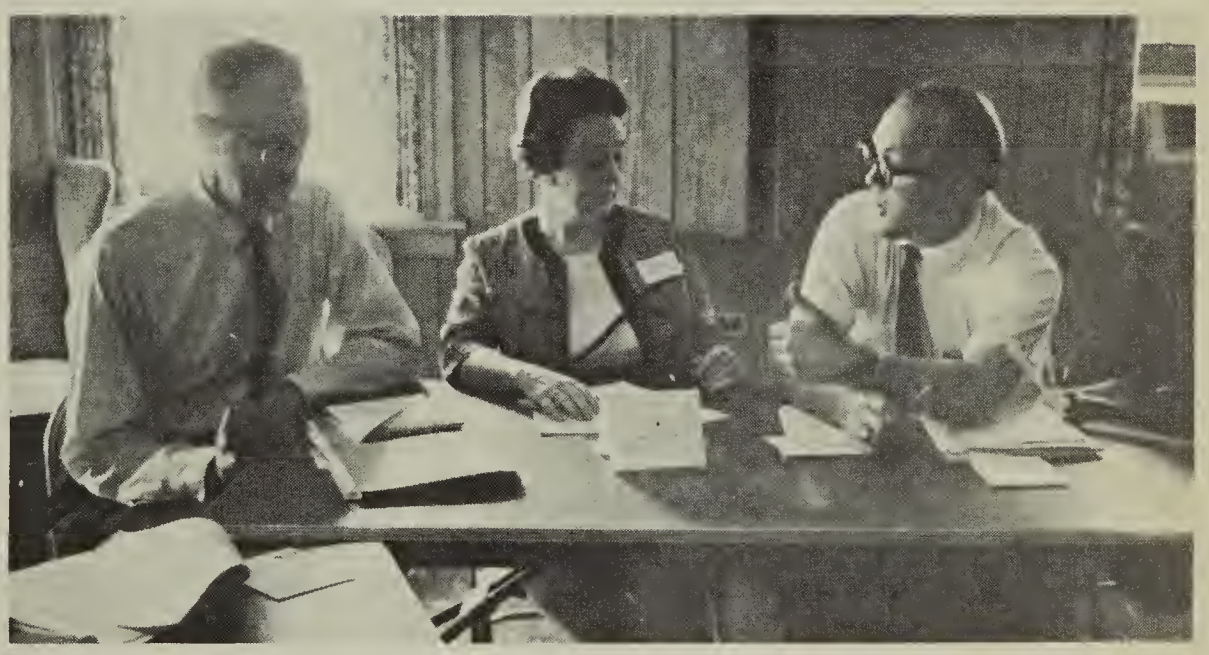
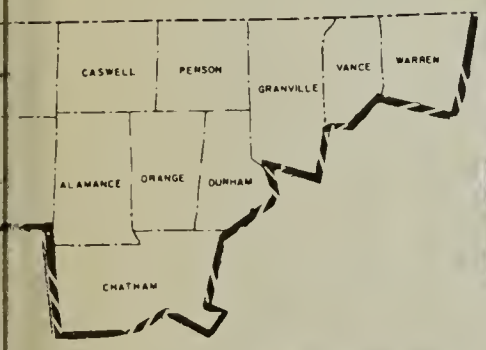
PLANNING MEETINGS

Eastern Region





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escape with the bottle in Act I, escape through the actions of others in Act II, and then deny that anything is wrong in Act III.

Sometimes recovery begins when members of the supporting cast in Act II die or get worn out with their roles and quit the play without notice. Or ideally recovery should begin when the provoker or victim seeks professional or other competent help and begins writing a different script, learning to act accordingly. If the alcoholic is allowed to be the author and director of the play as well as actor in the lead role, the result is inevitably tragic—an untimely death while others are destroyed in the process. The movement is one of denial which may be played passively or through subversion if necessary.

To understand the basic philosophy of recovery in this fashion, let us examine two simple factors on which industrial programs of alcoholic rehabilitation are based. One factor is the offering of help in the process of recovery. The second factor is the open and objective statement that the company refuses to be victimized. The latter is the key to recovery and the most important preparation for employees, especially the supervising group, so that the immediate superior understands his role in reporting the existence of alcoholism when it *first* interferes with job performance. Such programs have reported success rates of 60-90 per cent, depending upon the thoroughness of the company's industrial health program.

A psychiatrist I know has unusual success in providing therapy for the provoker. Working with the wife alone, his experience has been that half the husbands made a genuine recovery, one-third improved, and the drinking pattern failed to change in only one husband in six.

As an hypothesis I offer the idea that the primary reason for the lack of success in treatment in the field of alcoholism is that we are administering therapy to the wrong person. It should be administered to the spouse and parents, employer, and to the minister, doctor and lawyer of the alcoholic. Most professional persons have never had one single hour of objective instruction in the area of alcoholism throughout their entire careers. This goes for personnel directors, social workers, solicitors and judges, probation and parole officers, in addition to those just mentioned.

For the past few weeks I have been counseling a couple. The husband, a chronic alcoholic, is at the moment hospitalized for the first time for withdrawal. The wife is a physician just under forty years of age. Last year, in another section of our nation, this couple went jointly to a psychiatrist for a series of conferences. Both drank before and after the conferences but neither they nor the psychiatrist discussed alcoholism at any time. Week before last the doctor was appalled to learn that there is an alcoholic syndrome and that she and her husband had played out their roles in this drama almost to the letter.

Another long-term client of five years is hospitalized in a state some 500 miles from home. This person, a physician, spent eight months in four hospitals in 1965. When his wife removed herself as provoker, he respliced the umbilical cord and began

what role precedes recovery.

living with mother. His enablers have been legion, including his minister, many doctors, and mother's lawyer. The wife found it necessary to dismiss her own lawyer because of her husband's ability to subvert all legal matters. The new lawyer accomplished in one week what the other had failed to do in one year.

I have chosen these two illustrations for a specific purpose. If the ministers, doctors, and lawyers are part of the illness, how can the patient recover? If the minister becomes an auxiliary ego with no knowledge of the dynamics of the play, what are the consequences? If the patient is locked in a phase of resistance to treatment, who will break the lock? If the name of the game is denial and the supporting cast answers "yea, yea, yea," like a Greek chorus, how can the patient recover?

The focal point of counseling with the family of the alcoholic is helping family members understand the game they are playing, the role in which they are cast, and the probability of the content of Act III if they continue to play out Act II in the same fashion.

The real problem is the lack of knowledge of alcoholism plus a basic misconception of the role of spouse or parent. At the end of a recent interview a young wife stated, "Apparently I must go against what the Bible and church teaches me if I am to help my husband recover." Her definition of this teaching was, "Love my husband, forgive him and help him." Yet her love had been replaced by fear and separation had been in effect for a month. An older brother had just rescued the alcoholic from jail by paying hundreds of dollars for bad checks. The wife was bitter because none of his promises or agreements had ever been kept, and moreover he used the threat of drinking as blackmail. She had tried desperately to love, to forgive, and to help her husband according to the basic misconception of love, forgiveness and help which permeates our present moralistic, conformist society. In fact, however, her actions had helped him continue to drink rather than help him recover.

In coping with an alcoholic husband, the wife tries desperately to do what she has been taught to do by family, church and society. It doesn't work. She fails and finds herself destroyed in the process. Teaching the wife, the family, and other primary persons in the life of the alcoholic the dynamics of the play and who is playing what role precedes recovery. The key to therapy is enabling the supporting cast of Act II to acquire sufficient courage, based upon their acquired knowledge and insight, to free themselves to do what they really want to do. I do not find the wife the desperately sick and neurotic person many believe her to be, but rather an average person, in most instances, caught between an advancing complex mental illness of which she is ashamed and a feeling that there is no escape from her marriage vows or no adequate means of securing involuntary treatment for her spouse.

This woman can be wife, housekeeper, and earn some of the bread if need be, but she cannot play the roles of nurse, doctor and therapist to her husband which are forced upon her by society. I am constantly appalled at how often others demand the impossible of wives while refusing to recognize or admit all the failures imposed by the illness of the

(Continued on page 24)

ALCOHOLISM— AN EPIDEMIOLOGIC VIEWPOINT

BY WENDELL R. LIPSCOMB, M.D.

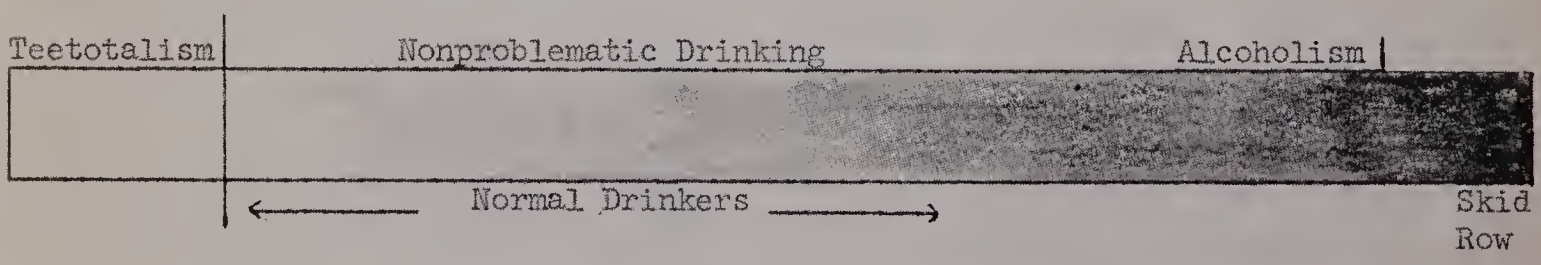
The "labeling process" approach to the study of alcoholism proposed by the author would make it possible to detect persons "at risk" of being labeled alcoholic long before they reach the stage that presently attracts public agency attention.

The author, Wendell R. Lipscomb, M.D., chief of research, Mendocino State Hospital, Talmage, California, is a former chief of research for the Division of Alcoholism, State of California Department of Public Health.

EPIDEMIOLOGISTS have become increasingly aware that there are many types of alcoholic beverages users which, when grouped, beg description and defy definition. The much studied skid-row individuals constitute only one small group in the total "alcoholic population." Similarly, the entire alcoholic population is only a small group of the extreme right end of an alcoholic beverage intake spectrum which runs from tee-totalism to chronic alcoholism.

There has been a great reluctance to acknowledge that the drinking practices of easily identifiable alcoholic populations had their beginnings among the "normal drinkers" of society. Modern alcoholism studies have focused not only on the far right of the alcoholic intake spectrum, but all along its length. Present convic-

Alcoholic Beverage Intake Spectrum



"Public health dreams of a time when there shall be enough for all and every man shall bear his share of labor in accordance with his ability, and every man shall possess sufficient for the needs of his body and the demands of health. These things he shall have as a matter of justice and not of charity. It dreams of a time when there shall be no unnecessary suffering and no premature deaths; when the welfare of the people shall be our highest concern; when humanity and mercy shall replace greed and selfishness and it dreams that all these things shall be accomplished through the wisdom of man. It dreams of these things, not with the hope we individually may participate in them, but with the joy that we may aid in their coming to those who shall live after us, when young men have visions—dreams of old men come true."

—Milton Rosenau

tion among epidemiologists is that there is a pressing need for studies that more clearly describe normal living, normal behavior, "normal health."

It is easily understandable that earlier studies on alcoholism tended to deal with groups of drinkers whose drinking practices and related or consequent behavioral events in their lives labeled them as different from other drinking populations. Older models for the study of the acute communicable diseases fail to meet the needs for study of chronic disorders such as alcoholism.

The following model depicts the classical approach of clinical medicine to the detection and labeling of a condition:

Model

In association with excessive sugar in urine:

(*Signs and Symptoms*)	(*Name of Process*)	(*Possible Origins of Process*)
Polyuria		Hormonal
Polyphagia	Process Diabetes	Metabolic
Polydipsia		Habit
		Secondary to Illness

This model indicates that when an observer discovers a high sugar content in an individual's urine and simultaneously the individual: (1) urinates very frequently (polyuria); (2) drinks fluids very frequently (polydipsia); and (2) eats very frequently (polyphagia) he may reasonably entertain the idea that the individual is involved with the diabetic process. The model indicates that further observation and study must be carried out to: (1) establish the validity of the labeled process, i.e. "clinch the diagnosis" and (2) attempt to learn the origins of the process in the afflicted person.

The probability of a person being labeled and treated as a diabetic would depend upon the extent to which these signs and symptoms are repeatedly observed and measured.

With great difficulty, alcoholism as a labeled process can be fitted to the same model:

Model

In association with excessive use of alcohol:

(*Signs and Symptoms*)	(*Name of Process*)	(*Possible Origins of Process*)
Poly A		Hormonal
Poly B	Process Alcoholism	Metabolic
Poly C		Habit
		Secondary to Illness

Once events A, B, and C are selected so that a "tentative diagnosis" can be attached, we are again faced with etiology, i.e., how did the process originate?

More and more it is seen that many different types of factors are at work in the production of chronic conditions, including such allegedly nonmedical phenomena as occupation, social pressure, patterns of child rearing, recreation and the use of leisure time.

Such factors now become part of the basic elements to be utilized in alcoholism study and include the essential idea of a "web of causation" approach to chronic disorders. From evidence gathered in many types of studies of "alcoholics" and also general population groups, it has been found that the pinning of the label "alcoholic" to a specific individual or group depends as much upon the community attitudes — folkways, mores—toward drinking as upon the clinical evidence detected in the physician's office.

Therefore, the determination of what criteria a given individual uses when he selects out from among his fellow citizens a person who drinks and calls him an alcoholic is crucial to the understanding of any alcoholism study. Certainly, should such criteria be determined and employed in early detection, potential alcoholics might be aided to avoid being labeled with the socially unacceptable epithet. Alcoholism in this concept

may thus be viewed as a labeling process; the risk of such labeling rising as evidence of lack of well being associated with drinking accumulates in the life space of a given drinking individual.

Of great importance is the fact *that labeling of a drinker's behavior also includes the reaction to his behavior.* This reaction may come from the observing, labeling public or from the drinker himself. The drinking individual who labels himself an alcoholic proceeds to act like an alcoholic in his reaction, whether drinking or not, e.g., Alcoholics Anonymous. This unit of behavior, plus reaction, *is* the problem to be studied. Such a concept has to be taken into account if any measurements of prevalence are to be of meaningful value.

Using this approach, we need not assume that the labeled drinker is on any predetermined path to pathology; the only process of which we are certain is the process of attaching the label to this individual. Hence, the behavior plus reaction is a unit to be counted for prevalence estimate. We need to place the unit under epidemiologic scrutiny with a more appropriate model.

First, it is seen that the behavior-reaction unit is composed of at least two analytically separable factors, each of which can vary independently of the other. The behavior may change and the label remain stuck to the individual (as member of A.A.) or the behavior could remain constant and the reaction to it change (such as might happen in a rapidly changing community). An extension of this thinking demands an investigation of the permanence of the label. Patently, one need not accept the label. This question, as suggested above, of accepting the label has a psychological component, e.g., being convinced that one *is* what one is called. And the study of the process of being convinced would make a study in itself, as would a study of the denial of the validity of the label.

The major problem in attempting to use this type of approach is to determine the limits of the consensus of opinion on which the label is applied. Is it but a single group in a community that defines "X" behavior as a criterion for labeling, or does the criterion have wider acceptance?

This approach to the study of alcoholism leads to an operational definition that can be stated as follows: Alcoholism is a behavioral syndrome (s) of unknown etiology, usually associated with intemperate drinking, which at some point in its development is characterized by measurably increased risk of certain types of social and clinical morbidity and/or mortality. Curiously enough, this definition is not at variance with those currently in use (Keller et al); however, it does include the concept of *risk.* The risk of being labeled an alcoholic is as much a function of the labeler as of those so labeled. Although the definition is couched in terms of alcoholism, singular, it is quickly apparent from the context that one must refer to *alcoholisms,* for cultural attitudes concerning drinking are as varied and diverse as the places, times, and feelings they represent. The late E. M. Jellinek clearly recognized this when he published in 1960 an article entitled "Alcoholism, a Genus and Some of Its Species."

The "labeling process" approach to the study of alcoholism does not exclude, but rather includes, the "progressive disease entity" approach. In the latter the labeling simply comes from clinical criteria and the frequency of such labeling

would rest on the interest, knowledge, and availability of numbers of treators or treatment facilities in a given area. In this case the practicing physician is in a most enviable position to assess and detect persons "at risk" of being labeled alcoholic, long before public agency attention is officially attracted.

For the epidemiologist in the study of alcoholism as a labeling process, then, some of his tasks must be:

1. To establish firm and accurate categories to describe drinking practices.

2. To determine how these practices are judged by society.

3. To cull from the reservoir of potential events in human life those most frequently associated with socially unacceptable and clinically harmful drinking practices, i.e., drinking practices judged to be part of the alcoholism process.

The size and complexity of these tasks warrants some borrowing by the epidemiologist from the academic disciplines which have traditionally studied human behavior. Concepts, methods and study operations developed by the behavioral sciences need to be linked with the epidemiologist's skills in statistics and clinical medicine.

The method has been successfully used as a tool for discovering clues to the relationship between health and illness in the population over many centuries. Our understanding of not only infections but also noninfectious and sometimes chronic processes is growing steadily.

In time, given the growing interest of behavioral scientists and merging their disciplines to spearhead the multidisciplinary attack on the alcoholism labeling process, we may see the diminution of this disease as we have seen the control of blindness in premature infants and poliomyelitis.

THE DRAMA OF ALCOHOLISM

CONTINUED FROM PAGE 19

husband. We do not expect a wife to play the roles of nurse, doctor and psychiatrist to a husband who is ill with a mental illness, unless this form of mental illness be alcoholism.

Alcoholism is the only disease named for a patent medicine which the patient prescribes for himself and administers in overdoses. Most persons in our nation drink, and excessive drinking which is not alcoholism is not unusual. In contrast it is not socially acceptable to serve goofballs, yellow jackets or narcotics and we do not use the term "heroic" or "barbituric" to describe persons addicted to these drugs. The mind of the public does not confuse the normal use of drugs with the addictive use of drugs unless it happens to be the old wonder drug, alcohol.

The word, alcoholic, though better than the word, drunk, is most inadequate in describing the illness of alcoholism. Moreover, the word, itself, brings two handicaps into recovery: moral condemnation in regard to drinking on the part of a minority within our culture and the resulting cultural contribution to some underlying guilt in regard to drinking on the part of most persons. We have seen what this attitude does to the family of the alcoholic in helping to perpetuate the illness.

Recovery is effected as the primary persons in the alcoholic's life gain the ability to understand and change the role they play in the perpetuation of the illness by permitting the alcoholic to continue the game of life he is playing. The name of this game is *Denial* and, if the alcoholic is allowed to play it under his rules, it will result in an untimely death for the drinker and destruction of the lives of those around him.

VOL. 15, NO. 6 INVENTORY MARCH-APRIL, 1966

ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

Withdrawal complications appear rather rapidly after the age of 35.

MANAGEMENT OF ALCOHOL Withdrawal STATES

BY HELEN WILLIAMS, M.D.

Dr. Williams is senior physician at the inpatient hospital for alcoholics at Avon Park, Florida. Her article is condensed from a paper published in the March, 1966, issue of the *Journal of the Florida Medical Association* as it was printed in the *Reporter,* a publication of the Florida Alcoholic Rehabilitation Program, P. O. Box 1147, Avon Park, Florida. Reprinted by permission.

FOR the alcoholic, the acute intoxication and withdrawal period presents the prospect of serious and sometimes fatal complications. Even in the absence of serious reactions, the alcoholic in withdrawal poses a difficult and time-consuming problem.

Differentiating between the patient who will just have a hangover in the morning and the one who will be critically ill remains difficult. Nevertheless, these are a few clues which may at least alert the physician to the likelihood of a difficult withdrawal period:

. . . . The first is age; many types of serious withdrawal appear to become considerably more frequent after the age of 35. Thereafter the complications appear rather rapidly within the next five years.

. . . Another one is the drinking pattern; the person who drinks every day and particularly the one who sips around the clock and is rarely without alcohol in his blood stream is decidedly more likely to have physical disturbances when alcohol is discontinued than the patient who drinks periodically.

. . . Of course, the longer the drinking bout and the larger the quantity consumed, the greater the difficulty experienced in drying out.

. . . Other physical illnesses, particularly cardiovascular, respiratory, renal, hepatic or pancreatic disease, present serious problems when they complicate alcohol withdrawal.

. . . The concomitant long-term use of sedative or ataractic drugs with alcohol also makes detoxication difficult.

The withdrawal symptoms begin as the patient's blood alcohol level falls below the level to which he has become habituated. *Typically this is eight to 12 hours after his last drink.* In some cases, however, it may begin while he is still sipping a little in an effort to taper off. The reaction, if untreated, increases in severity during the second and third days and, unless complications have developed, begins to improve after the third day. *Nevertheless, seven to* 10 *days usually elapse before the patient has actually recovered from the episode.*

The complications of the withdrawal period are numerous, and range from those which are merely

annoying to the patient to those which are of critical importance. Probably those which come to mind most quickly are shakes and delirium tremens. Actually these seem to be different degrees or intensities of the same phenomenon, the mildest expression being a subjective sensation of quivering or shaking which the patient calls the "inside shakes," a more severe symptom being the gross tremor with vivid nightmares and hallucinations, and finally delirium tremens being the extreme form. *The cause of these symptoms is still not definitely known.* They appear to be related in part to the actual withholding of alcohol from the system and they are usually relieved temporarily by giving alcohol, or, at times, a tranquilizer. They also seem to be influenced by the patient's state of health and nutrition, by infection, trauma, surgery or complicating illness. *Once delirium tremens develops, the mortality is at least* 10 *per cent and in many series much higher,* occasionally up to 25 to 35 per cent where accident victims are numerous.

Although delirium tremens may develop rapidly, it rarely occurs suddenly without premonitory signs. Restlessness and agitation become marked; the patient paces the floor, rearranges his room or packs his suitcase. He becomes more anxious and repeatedly asks the nurse if his condition and behavior are satisfactory. At the same time he becomes less willing to follow instructions and generally louder in his talk and less cooperative. He professes extreme tiredness but is unable to sleep or even be still. He begins to misidentify persons he sees and finally to hallucinate. This condition develops over a period of several hours, more often than not, during the late afternoon and night hours. If the patient can be given heavy doses of phenothiazine or sufficient sedative drug to induce sleep during this period, frank delirium can usually be prevented. If it is permitted to progress until morning, delirium tremens is usually established.

In milder withdrawals, motor symptoms may predominate over psychic, and complaints center around severe tremors which interfere with eating and activity, muscle twitching and muscle cramps. Among the more toxic patients in this group, neurologic and special sense disturbances are likely to be troublesome and disturbances in vision, hearing and equilibrium are frequent. Seizures occasionally occur. In addition, numbness and tingling of the extremities and severe generalized itching of the skin cause a great deal of concern to the patient.

Restore Balanced Nutrition

Through lack of food and poor general living habits, the alcoholic has often become seriously debilitated. It is essential that his nutrition balance be restored as rapidly as possible and that he be protected from complications, such as infections, while this restoration is being accomplished.

Perhaps the most vital step is adequate hydration and balancing of electrolytes. During a drinking spree the fluid intake is usually inadequate to meet body needs. Since mineral intake is also deficient, an electrolyte imbalance complicates the problem. The patient may be admitted with localized or general edema which is, in effect, dehydrated insofar as his intercellular water is concerned. The patient in alcohol withdrawal needs at least 3,000 cc. of water per day. During delirium tremens he probably needs twice this amount.

Until electrolyte imbalances are corrected, supplying water serves little purpose. Although much work remains to be done concerning the nature and extent of the electrolyte disturbance, the following are frequently reported in the literature and are frequently seen in our experience:

1. *Potassium levels are usually low.* Correction of a deficiency here may be of vital importance to stabilize both heart and liver function.

2. *Sodium levels are variable, but are frequently low.* The patient usually seeks out salty foods on his own and correction is seldom difficult.

3. *Magnesium is usually deficient.* Reports on low serum levels are contradictory and inconclusive, but low spinal fluid levels are rather consistently reported in the literature. We almost routinely give magnesium sulfate intramuscularly if the patient's condition is poor, unless he is in a coma.

4. *Calcium is frequently a little low, but rarely low enough to produce symptoms.* Occasionally acute deficiencies with tetany occur.

5. A metabolic acidosis is frequent due to the accumulation of lactates, but is rarely severe.

Prevention or correction of vomiting greatly facilitates stabilizing the electrolyte systems and we routinely start an intoxicated patient on antiemetics, usually of the meclizine hydrochloride (Bonine Hydrochloride) or dimenhydrinate (Dramamine) type on admission.

Mild to severe deficiencies in the B vitamins are the rule in alcoholics. There is some evidence that either the need for these is increased in alcoholics or the capacity to utilize them is decreased. *In any case, the alcoholic seems to require much greater than average dosage of B complex.*

The problem of proteins has long plagued the physician working with alcoholics. The patient is usually already in negative nitrogen balance and physiologic functioning and tissue repair cannot begin until protein is supplied. Some degree of liver involvement, however, either transient or permanent, is present in the majority of patients at the time of sobering up. It has been conclusively demonstrated that the bulk of the fats which accumulate in the liver is transported there from the peripheral tissues and deposited there rather than being formed there. Nevertheless they do interfere with normal hepatic functioning, including the ability to metabolize proteins. *This situation leaves the clinician in a dilemma;* he must supply protein yet the liver cannot metabolize it normally.

Serious Complications

These are a few potentally serious complications for which the physician should be alerted during withdrawal:

1. *Congestive heart failure.* This is difficult to diagnose at this time, as enlargement of the liver, dependent edema and chest rales are usually already present. It is important to diagnose even mild failure, as congestion in the liver further compromises its already poor functioning. A persistently rapid pulse should arouse one's suspicions, and electrocardiographic findings and chest films should make diagnosis possible. Whether failure is due entirely to deficiencies in thiamine and potassium or whether an alcoholic myocardiopathy exists as a separate entity is being studied, but is not clear at this time.

2. *It should also be mentioned that blood pressure tends to be elevated,*

but is unstable during the first 24 *to 36 hours of withdrawal.* During this period parenteral administration of phenothiazine drugs may cause severe hypotension and is potentially hazardous. Hydroxyzine (Vistaril) or chlordiazepoxide hydrochloride (Librium) is safer during the initial phase, but may be replaced by phenothiazine after 36 hours if indicated.

3. *Hepatic coma may, of course, result in the course of advanced cirrhosis.* It may, however, also occur without cirrhosis in alcoholics who have been on a heavy drinking spree, presumably because of the poor functioning of liver cells which are filled with fat. Its onset may be suspected when a flapping tremor develops *along with* lethargy and confusion. It can often be controlled by giving neomycin or if due to kidney disease, oxytetracycline (Terramycin). Sometimes intravenous infusions of arginine or glutamate seem to be helpful. If the condition progresses to actual coma, protein must be eliminated from the diet.

4. *Hemorrhage from esophageal varices occurs rather infrequently, but is an acute emergency when it does occur.* It can sometimes be controlled by giving intravenous surgical pituitrin, 20 units in 200 cc. of glucose. If this fails, tamponade and surgical intervention must be attempted.

5. *Infections, even minor ones, tend to become severe and to contribute to decompensation of the liver.* If low grade fever and leukocytosis are present, the physician must look for an infectious process and treat it intensively.

6. There have been some reports of hypoglycemic reactions following drinking. These have sometimes proved fatal. The mechanism is not clear, but may be due to a vagally induced hyperinsulinism. There may also be occasional high blood sugar levels which normalize after drying out.

The aims of detoxication are (1) to restore the patient to a normal physiologic state as rapidly as possible, (2) to prevent the complications of withdrawal, and (3) to persuade the patient to seek treatment for the alcoholism. To accomplish the first of these objectives the patient must be supplied with the essential nutritional elements which he needs. They must be given quickly and in adequate amounts. To accomplish the second, some replacement for the alcohol withdrawal must be provided and this may be reduced gradually over a period of several days.

Alcoholism is an illness which produces profound but still poorly understood changes in the patient. Recent studies indicate disturbances in the metabolism of carbohydrates, fat, proteins and probably also the catecholamines. These are added to the effects of withdrawal of a depressant drug to which the patient has become habituated. In addition, some degree of malnutrition is usual.

The severity of an alcohol withdrawal reaction may often be anticipated by considering the age of the patient, his drinking history, general health, and concomitant use of other drugs.

A withdrawal reaction is typically disabling for three to five days and may present serious complications.

Careful attention to fluid and nutritional needs, together with substitution of sedative or ataractic drugs for alcohol will shorten the period of disability and aid in prevention of many complications.

Close observation and early treatment will decrease mortality from the serious complications which develop.

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DOES IT REALLY

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miseries that accompany uncontrolled drinking. It must be empathy.

How then, we may ask, can a non-alcoholic get this necessary understanding? How can a professional person learn it? There may be more ways than one, but one sure road to understanding is simple: Ask (and believe) the alcoholic!

On the other hand, the reality of dealing with the alcoholic personality must be acquired. Again, ask the alcoholic. Let him tell what slick tricks he's played in his drinking life. Get him to tell you to what means he has gone to get a drink . . . and another . . . and another.

When the above education of the non-alcoholic is successfully completed, the alcoholic will accept him. Whether he be a highly trained professional or interested layman, he is then ready to offer his unique contribution to those needing help.

Whatever his discipline—whether he comes from the ranks of medicine, psychology, social work, the clergy, or others—he can rest assured of one thing: if he demonstrates to the alcoholic that he has the understanding and other qualities already mentioned, the alcoholic will eagerly reach out to listen to him.

The alcoholic is thirsty for more things than one. He is thirsty, for instance, for knowledge. He craves information about the physiology of his illness, he looks for answers to the perplexing psychological factors of his makeup, he wants guidance in family affairs, and above all, he wants a restoration of his faith.

The answer to the question of whether alcoholics should be treated by other alcoholics or professional people is: both.

—Florida ARP Reporter

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ASHEVILLE—

**Alcohol Information Center;* Mike Dechman, Educational Director; Parkway Offices; Phone: 704-252-8748.

†*Mental Health Center of Western North Carolina, Inc.;* 415 City Hall; Phone: ALpine 4-2311.

BURLINGTON—

**Alamance County Council on Alcoholism;* R. J. Cook, Executive Director; Room 802, N. C. National Bank Building; Phone: 919-228-7053.

‡*Outpatient Clinic;* Alamance County Hospital; Hours: Wed., 9:00 a.m. - 4:00 p.m.

BUTNER—

‡*Aftercare Clinic;* John Umstead Hospital; Hours: Mon. - Fri., 9:00 a.m. - 4:00 p.m.

CHAPEL HILL—

†*Alcoholism Clinic of the Psychiatric Outpatient Service;* N. C. Memorial Hospital; Phone: 942-4131, Ext. 336.

**Orange County Council on Alcoholism;* Calvin Burch, Box 277, Carrboro; Phone: 919-942-1089 or (if no answer) 919-942-1930.

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**Charlotte Council on Alcoholism;* Rev. Joseph Kellermann, Director; 1125 E. Morehead St.; Phone: 704-375-5521.

‡*Mecklenburg Aftercare Clinic;* 1200 Blythe Blvd.; Hours: Mon. - Fri., 8:00 a.m. - 5:00 p.m.

†*Mental Health Center of Charlotte and Mecklenburg County, Inc.;* 316 E. Morehead St.; Phone: 704-334-2834.

CONCORD—

†*Cabarrus County Health Department;* Phone: STate 2-4121.

DURHAM—

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**Durham Council on Alcoholism;* Mrs. Olga Davis, Executive Director; 602 Snow Bldg.; 919-682-5227.

FAYETTEVILLE—

†*Cumberland County Guidance Center;* Cape Fear Valley Hospital; Phone: HUdson 4-8123.

GASTONIA—

†*Gaston County Health Department;* Phone: UNiversity 4-4331.

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‡*Outpatient Clinic;* Cherry Hospital; Hours: Tues. and Fri., 10:00 a.m. - 12:00 noon. Thurs., 2:00 - 4:00 p.m.

**Wayne Council on Alcoholism;* H. B. Hulse, Executive Director; P. O. Box 1598. Phone: 919-735-7033.

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**Greensboro Council on Alcoholism;* Worth Williams, Executive Director; 216 W. Market St., Room 206 Irvin Arcade; Phone: 919-275-6471.

†*Guilford County Mental Health Center;* 300 E. Northwood St.; Phone: BRoadway 3-9426.

†*Family Service Agency;* 1301 N. Elm St.

‡*Outpatient Clinic;* 300 E. Northwood St.; Hours: Mon. and Thurs., 5:00-10:00 p.m.

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**Pitt County Alcohol Information and Service Center;* Helen J. Barrett, Executive Secretary; P. O. Box 2371; 915 Dickinson Ave.; Phone: 919-758-4321.

†*Pitt County Mental Health Clinic;* Pitt County Health Department, P. O. Box 584; Phone: PLaza 2-7151.

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**Vance County Program on Alcoholism;* Dr. J. N. Needham, Director; 2035 Raleigh Rd.; Phone: 919-438-3274 or 919-438-4702.

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Alcohol Information Center; S. Robertson Cathey, Director; 2nd Floor, City Hall; Phone: 919-692-8118.

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**Alcohol Education Center;* Ben Garner, Director; P. O. Box 348; Phone: 919-883-2794.

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**Scotland County Citizens Council on Alcoholism;* M. L. Walters, Executive Secretary; 308 State Bank Bldg.; P. O. Box 1229; Phone: 919-276-2209.

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‡*Aftercare Clinic;* Broughton Hospital; Hours: Mon.-Fri., 2:00-4:00 p.m.

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*†*Psychiatric Social Service,* Craven County Hospital; Phone: 919-638-5173, Ext. 294; Hours: Mon.-Fri., 9:00 a.m.-5:00 p.m.

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‡*Aftercare Clinic;* Dorothea Dix Hospital, S. Boylan Ave.; Phone TEmple 2-7581; Hours: Mon.-Fri., 1:00-4:00 p.m.

†*Outpatient Clinic of the Mental Health Center of Raleigh and Wake County, Inc.;* Wake Memorial Hospital; Phone: 834-6484; Hours: Mon.-Fri.; 8:30 a.m.-5:30 p.m.

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†*Cleveland County Mental Health Clinic;* 101 Brookhill Rd.; Phone: 482-3801.

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**Education Division, Board of Alcohol Control;* Robert M. Kendall, Director; 125 W. Wade St.; P. O. Box 29; Phone: 704-694-2711.

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**Mental Health Center of New Hanover County;* 920 S. 17th St.; Phone: 763-7342.

**New Hanover County Council on Alcoholism;* Mrs. Margaret Davis, Executive Secretary; 211 N. Second St.; P. O. Box 1435; Phone: 919-736-7732.

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‡*Aftercare Clinic;* Encas Station; Hours: Mon.-Fri., 8:00 a.m.-5:00 p.m.

†*Wilson County Mental Health Clinic;* Encas Rural Station; Phone: 237-2239.

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